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Macroeconomics and health

Despite shortcomings the plans in this report deserve strong support

Macroeconomics and Health, a provocative report from the World Health Organization, is a dramatic call for action from both rich countries and poor countries.[1] The report emphasises the linkage of avoidable disease to poverty and argues that investments in health are fundamental to and perhaps a prerequisite for economic development. The report proposes a massive increase in funding for health in the poor countries, with a fivefold increase in support from wealthy countries and at least a doubling from the poor countries themselves.

The key recommendation is for the world's poor countries to work in partnership with high income countries to scale up their health systems to provide access for all to a limited number of essential health interventions. Although emphasising the partnership of the poor with the rich, the report is primarily an advocacy document addressed to the donor nations. It requests the high income countries to resolve "that lack of donor funds should not be the factor that limits the capacity to provide health services to the world's poorest people."

The argument that poor health in and of itself is a major contributor to poverty and that relatively small investments in health could lead to dramatic improvements in health and development, though hardly new, is coherently and eloquently expressed. It should not be cynically dismissed as an unrealistic and ineffective giveaway.

The arguments are well articulated, but the technical underpinnings are weak—although six working groups developed 91 background reports over 24 months. The technical components of the report include the role of poor health in the production of poverty, the strategy of scaling up essential interventions to all (particularly for infectious disease control—HIV and AIDS, malaria, and tuberculosis—nutrition, and maternal health) largely through what is termed "close to the client" services (basically what had been called primary health care in the Alma Ata declaration), the costs to scale up the interventions, the health gains to be expected from these, and the economic development and income returns from these health gains.

The evidence linking poor health to poverty or, more positively, better health to economic growth, is strong. But the report itself points out that further research is needed to establish a causal role for improved health.

The estimated incremental costs for the poor countries to scale up the essential interventions to all, and the estimated resulting gains in healthy lives, would seem reasonable if applied to ongoing, truly functional health systems—but these are rarely found among the least developed countries. To overcome the constraints faced by the majority of least developed countries—well outlined in a paper[2]—will require enormous political and social reforms before meaningful investment in the health system and the complementary infrastructure for education, transport, and communication can take place. The unlikely feasibility of any useful investment in countries without a functional health infrastructure is not discussed.

The numbers used are based on expert estimates about what should be able to be accomplished and draw heavily from estimates assembled by WHO's global burden of disease group. Scepticism about such numbers in the aftermath of the *WHO Report 2000* are inevitable.[3] The use of such normative estimates points to the need for actual data from the poor countries both on effects of interventions and on their costs.

The economic development and the income gains from effective implementation of the essential interventions in the poor countries are asserted without any obvious empirical basis. The basis for the statement that a disability adjusted life year (DALY) gained is worth at least an average annual income per head is not at all evident. Economists normally count the marginal wage in less developed countries as zero since rampant unemployment and underemployment are the norm.

Although the estimated fivefold increase in funding from donors required to support the scale up is only 0.1% of the gross national product of donors, it will be a major political challenge in most wealthy countries, especially the United States, to obtain a fraction of this amount. But the real problems lie with the poor countries, most of which lack the capacity to carry out the planning and management that such a large increase in resources would entail. The report acknowledges that the poor countries must provide strong political leadership, initiative, mobilisation, and organisation with appropriate community governance and accountability mechanisms. To obtain funds each country must establish a national commission to develop a comprehensive and realistic blueprint for the use of increased funds, and the report outlines a series of tasks that must be carried out for this to happen. But a major weakness is that criteria, standards, and mechanisms for judging the blueprints and for monitoring their

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implementation are not discussed. Presumably these will be established soon; donors should require them before committing funds.

Despite the technical shortcomings of the report, the plans laid out for a partnership of the rich and poor countries to provide the resources greatly to scale up essential health interventions to all deserve strong support and immediate action from us all.

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1 World Health Organization. *Macroeconomics and health: investing in health for economic development. Report of the commission on macroeconomics and health*. Geneva: WHO, 2001.
2 Vergin H. Constraints to the scale-up of priority interventions: factoring in quality of governance and policy framework. Commission on Macroeconomics and Health (CMH) working paper series, paper no. working group 5: 24. World Health Organization, Geneva, 2000. www.cmhealth.org/docs/wg5_paper24.pdf (accessed 24 April 2002.)
3 World Health Organization. *The world health report 2000. Health systems: improving performance*. Geneva: WHO, 2000.

A time for global health

A global effort on health could inspire, unite, and produce substantial improvement

The life expectancy of the 642 million people in sub-Saharan Africa is 51 years, 27 years less than that of those who live in rich countries. Mortality among those aged under 5 is 25 times higher in Africa than in rich countries. The World Health Organization's Commission on Macroeconomics and Health, which reported at the end of 2001, estimates that by 2010 about 8 million lives a year could be saved in low income countries by investing large sums and acting through simple and effective interventions.[1 2] But will it happen? The rich countries have a poor record in fulfilling their promises to poor countries. Nevertheless, a small group of people with considerable influence on global health who met recently in California agreed that the lives might be saved. Raising expectations too high could lead to huge disappointment, but the opportunities for substantial improvement in global health are probably better now than at any time in the past 20 years.

Perhaps because of the report of the Commission on Macroeconomics and Health health is "fashionable" with world leaders in a way that it never has been before. Some 60 world leaders—including both Fidel Castro and George Bush—vied with each other to emphasise their commitment to health at the recent meeting on development financing in Monterrey, Mexico. The general assembly of the United Nations for the first time last year devoted a session to a health topic—HIV and AIDS. The last four summit meetings of the G8 (the rich countries' club) have included more debates on infectious disease than on nuclear safety.

The interest of world leaders in health is being driven by increasing recognition that investment in health is a motor for development and that global health and global security are inextricably intertwined. The Commission on Macroeconomics and Health was dominated by economists and financiers, not health experts—so giving greater credibility to its conclusion that an investment of $119bn (£158bn) in health each year by 2015 will produce a return of $360bn a year. It will do this by saving lives, allowing people to be economically productive, and by spurring economic growth through a variety of mechanisms including a faster demographic transition to lower fertility rates, higher investments in human capital, increased household saving, increased foreign investment, and greater social and macroeconomic stability.[1] The evidence base for some of this is weak,[2] but few dissent from the fundamental notion that investment in health is not "a nice extra" but essential for economic growth. Certainly, no investment in health is likely to mean no growth.

Rich countries as well as poor countries would benefit from this economic growth. Some of the thinking that led to the commission was that both rich donors and governments of poor countries would be more likely to invest in health if what might be called "a business plan" showed economic return. Since the commission began, however, and since the attacks of September 11 the world has come to worry as much about security as about economic growth. There is as yet no commission on global security and health, but security experts are concerned about health, particularly AIDS, malaria, and drug resistant tuberculosis. The United States, which gives a much lower proportion of its gross national product in aid than any other rich country, may well be persuaded to increase aid by anxieties about its own security. This has already begun, and as one contributor to the California meeting said: "I'd much rather they gave me aid because they feared me rather than pitied me." But then again, if security is the reason for giving aid the money may well not go to those who suffer the most but rather to those who present the biggest threat.

The commission's formula for improving health is in essence investment by both rich countries and poor countries plus reform. There is often debate about which should come first with the poor countries preferring money from the rich and the rich favouring reform in the poor countries. The commission concludes that both are needed simultaneously, but much of the world's current inadequate aid is unspent, and too many of the world's poorest countries are run by gangsters who care little for their people, particularly women and children. Little satisfaction is to be had from watching a corrupt government use aid to feed its soldiers to keep the corrupt in power. Aid, just like medicines, can sometimes make problems worse rather than better. Some countries are in such disarray that little can be achieved. The chances, for example, of rolling back malaria in Sierra Leone in the next five years are probably non-existent, whereas much might be achieved in more stable countries such as Ghana or Tanzania. Should aid therefore be given first to such countries? These are difficult questions.

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